Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARRIS METHODIST - FORT WORTH
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name
AMERICAN INTERSTATE INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-06-4368-01

MFDR Date Received
March 2, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Qualify for Stop loss"

Amount in Dispute: $11,927.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is our position that the bill in question has been overpaid, per the letter of explanation attached by our bill review company, Concentra Integrated Services."

Response Submitted by: American Interstate Insurance Company, 2301 Highway 190 West, DeRidder, LA 70634

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2005 to March 3, 2005	Inpatient Services	$11,927.57	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. 28 Texas Administrative Code §124.2 sets out carrier reporting and notification requirements.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
6. This request for medical fee dispute resolution was received by the Division on March 2, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to

disputes filed on or after January 1, 2003, the Division notified the requestor on March 14, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.

7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F – Fee guideline MAR reduction
   - (855-002) – RECOMMENDED ALLOWANCE IS IN ACCORDANCE WITH WORKERS COMPENSATION MEDICAL FEE SCHEDULE GUIDELINES. $3,560.48
   - G – UNBUNDLING
   - (855-013) – PAYMENT DENIED - THE SERVICE IS INCLUDED IN THE GLOBAL VALUE OF ANOTHER BILLED PROCEDURE. $0.00
   - M – NO MAR
   - (647-002) – REIMBURSEMENT HAS BEEN CALCULATED BASED ON A PERCENTAGE OF THE CHARGES.
   - N – NOT APPROPRIATELY DOCUMENTED
   - (855-022) – CHARGE DENIED DUE TO LACK OF SUFFICIENT DOCUMENTATION OF SERVICES RENDERED $0.00.
   - R – EXTENT OF INJURY
   - (855-010) – NC (NON - COVERED) PROCEDURE OR SERVICE, PAYMENT DENIED $0.00
   - 42 – Charges exceed our fee schedule or maximum allowable amount.
   - (930-015) – THIS CLAIM HAS EXCEEDED $5000
   - 97 – Payment is included in the allowance for another service/procedure.
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - (855-002) – RECOMMENDED ALLOWANCE IS IN ACCORDANCE WITH WORKERS COMPENSATION MEDICAL FEE SCHEDULE GUIDELINES. $9,826.85
   - W12 – Extent of injury. Not finally adjudicated.
   - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - (855-016) – PAYMENT RECOMMENDED AT FAIR AND REASONABLE RATE $175.00
   - (855-016) – PAYMENT RECOMMENDED AT FAIR AND REASONABLE RATE $244.00
   - (855-016) – PAYMENT RECOMMENDED AT FAIR AND REASONABLE RATE $338.00

Findings

1. The respondent denied disputed services with reason codes R – "EXTENT OF INJURY," and W12 – "Extent of injury. Not finally adjudicated." Per former 28 Texas Administrative Code §133.307(e)(4), effective January 1, 2003, 27 *Texas Register* 12282, if a dispute involves issues of compensability or extent of injury, "the respondent shall attach any related TWCC-21s in accordance with §124.2 of this title." Review of the submitted information finds no form TWCC-21. The Division concludes that the respondent has not met the requirements of §133.307(e)(4). These denial reasons are not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. The respondent further denied disputed services with reason code 42 – "Charges exceed our fee schedule or maximum allowable amount." Review of the submitted information found no documentation to support that the disputed services were subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
3. This dispute relates to inpatient hospital services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 823.00. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
4. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
5. 28 Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not

provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

6. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 Texas Register 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
7. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that the disputed services "Qualify for Stop loss."
   - The Division's former *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.401 is not applicable to the services in dispute. Per §134.401(c)(5)(A), when ICD-9 codes 800.0-959.50 are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Therefore, the applicable rule for reimbursement is found under §134.1(d).
   - The requestor asks for reimbursement under the stop-loss provision found in former 28 Texas Administrative Code §134.401(c)(6). However, §134.401(c)(6) states that "The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate." As stated above, the Division has found that the primary diagnosis is a diagnosis code specified in §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to §134.1.
   - The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

     "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

     Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	December 14, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.